

More on the Prostate Cancer Screening Controversy

TO THE EDITOR: As expected, Michael Cher, MD, and Peter Carroll, MD, gave the urologists' view of the controversy surrounding prostate cancer screening.¹ I could handle the improperly defined term (length-time bias). I could even handle the selective use of statistics (they claim that about a quarter of the prostate cancers that will occur in the lives of 50-year-old men will be "clinically significant," but their reference points out that only 7% of the cases will be fatal²) and the fact that their recommendations run directly counter to the 1994 recommendations of the US Preventive Services Task Force.³ It was their last paragraph, however, that shocked me into writing this letter.

Prostate cancer treatment has proven risks, the screening programs lack documented efficacy, and there is a tremendous psychological burden associated with being labeled as having an elevated prostate-specific antigen (PSA) level. Despite these factors, Drs Cher and Carroll "recommend that relatively young, healthy, asymptomatic men obtain a serum PSA assay" and then offer informed consent (that is, patient education of the risks and benefits of treatment) only after the positive results are known.

All patients should be counseled before obtaining a PSA level. To do anything less undermines our ultimate goal, the optimal care of our patients.

THEODORE G. GANIATS, MD
Department of Family and Preventive
Medicine, 0807
University of California, San Diego
9500 Gilman Dr
La Jolla, CA 92093-0807

REFERENCES

1. Cher ML, Carroll PR: Screening for prostate cancer. *West J Med* 1995; 162:235-242
2. Seidman H, Mushinski MH, Gelb SK, Silverberg E: Probabilities of eventually developing or dying of cancer—United States, 1985. *Ca Cancer J Clin* 1985; 35:36-56
3. The US Preventive Services Task Force: Screening for prostate cancer: Commentary on the recommendations of the Canadian Task Force on the Periodic Health Examination. *Am J Prev Med* 1994; 10:187-193

* * *

Drs Cher and Carroll Respond

TO THE EDITOR: Theodore Ganiats, MD, incorrectly concludes that we do not provide informed consent regarding the risks and benefits of screening for prostate cancer (that is, obtaining a serum prostate-specific antigen [PSA] level in men visiting our office without signs or symptoms of prostate disease). In fact, the abstract clearly states, "men should be informed regarding the benefits and possible risks before being screened for prostate cancer." In the last paragraph of the article, we indeed said that we recommend to certain men visiting our clinic that they obtain a serum PSA test as a screen for prostate cancer. We feel that, as physicians, we have the right, and even the responsibility, to provide our patients with opinions and recommendations based on

our review of the complex mass of available data. We anticipate that Dr Ganiats does the same, if he has clinical responsibilities.

We support decisions made by our patients with respect to all aspects of their care, including their decisions regarding screening for prostate cancer. The purpose of our article, in which we said that "there are no data to confirm that screening reduces morbidity and mortality" and "without these [data] the net benefit of screening cannot be calculated and predicted," was to provide the readers of *THE WESTERN JOURNAL OF MEDICINE* a timely review of the available data. We attempted to include the best information currently available on this subject. If Dr Ganiats has additional information, we would welcome his sending it to us. We hope that our review will allow practitioners to provide better informed consent, recommendations, and opinions to the men visiting their offices.

MICHAEL L. CHER, MD
PETER R. CARROLL, MD
Department of Urology, U-575
University of California, San Francisco,
School of Medicine
San Francisco, CA 94143-0738

Telephone Use and Costs in a Group Subspecialty Practice

TO THE EDITOR: Telephone communication is a major activity in physicians' offices, yet little study of this has been done. We analyzed our practice's phone use for the first three months of 1994, using software that allows for the collection of data on phone use. Our practice, a five-physician group, is limited to gastroenterology and serves a statewide referral base in New Mexico, using several satellite clinics.

We gathered information from three sources: our main office telephone system (Executone Integrated Digital System), cellular phones, and our answering service. Our system allows for extension-specific tracking of the number of calls and the duration of each call. Physician and nonphysician phone time could be distinguished and quantitated. Our phone system has no voice-mail component, and facsimile (fax) use was not tracked. All physicians also use radio pagers and mobile cellular phones. Calls to and from satellite offices, hospital wards, and homes could not be tracked. Because one of our physicians (on the average) was either at a satellite office or on a hospital ward, we assumed that the data we collected reflected the phone use of the equivalent of four of our five physicians.

Cost estimates were made, and phone bills, equipment costs, and nonphysician labor costs were tallied. For this analysis, we assumed that nonphysician employees require \$10.50 per hour to cover salary and benefits. Omitted from the cost estimates were physician time, office space, and miscellaneous support for persons using the phone. The time preparing for calls, time between calls, and time required to be available for calls were not counted.

Our practice recorded 9,727 uses of the telephone per month, totaling 395 hours per month. The average call lasted 2 minutes, 26 seconds. Physicians' calls lasted about twice as long as nonphysician calls. Physicians talked 73 hours, 54 minutes per month (18 hours, 29 minutes per physician per month; 4 hours, 37 minutes per physician per week). There were wide variations in the length of conversation among the physicians. Insurance- and billing-related calls tended to be longer than appointment scheduling, procedure scheduling, and clinical data-gathering calls.

Telephone bills charged to our practice for all services were \$2,062 per month, wage and benefit costs of nonphysician employees talking on the phone were \$3,370 per month, and phone equipment depreciation was \$370 per month. The total cost per physician per month was \$1,160. After salaries, malpractice insurance, and rent, telephone-related costs were the fourth most costly budget item in the practice.

Our data confirm that telephone communication is a major part of the practice of medicine. Our cost estimates, which exclude physician time and staff time between calls, are substantial, yet probably low. Physicians should carefully analyze telephone and other office communication because inefficiencies can generate substantial unnecessary costs. Further study in a variety of practice settings is warranted. We also speculate that because so little data are available, telephone costs are underrepresented in the policy-making considerations of elected government officials, government regulators, and insurance companies. They are also poorly appreciated by patients and physicians themselves.

HOWARD K. GOGEL, MD
ROBERT M. LYNN, MD
JOHN A. BURDON, MD
JAMES E. MARTINEZ, MD
JOSEPH M. ALCORN, MD
NANETTE ROMERO, LPN II
201 Cedar St SE, Ste 702
Albuquerque, NM 87106

The Editors are pleased to receive letters commenting on articles published in the journal in the past six months, as well as information or short case reports of interest to our readers. ALL MATERIAL SUBMITTED FOR CONSIDERATION MUST BE DOUBLE-SPACED. Letters NO LONGER THAN 500 WORDS are preferred. An original typescript and one copy should be submitted. All letters are published at the discretion of the Editors and subject to appropriate editing. Those of a scientific nature will be peer reviewed. Authors should include information regarding conflict of interest, when appropriate ("I warrant that I have no financial interest in the drugs, devices, or procedures described in this letter"). Most letters regarding a previously published article will be sent to the authors of the article for comment. Authors of accepted letters will have an opportunity to review the edited version before publication.